FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004077

Facility Name: Ambassador Nursing Center

Address: 4900 North Bernard (Number) Chicago (City) 60625 (Zip Code)

County: Cook

Telephone Number: (773) 583-7130 **Fax #** (773) 583-3929

HFS ID Number: 362900425001

Date of Initial License for Current Owners: 05/15/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Marvin Fox, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	190	Skilled (SNF)	190	69,350	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,874	2,154	4,594	31,622	8
9	SNF/PED					9
10	ICF	21,545	631	272	22,448	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,419	2,785	4,866	54,070	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.97%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/15/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 190 and days of care provided 4,214

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	440,208	27,395	10,806	478,409		478,409		478,409			1
2	Food Purchase		219,175		219,175	(26,061)	193,114	(112)	193,002			2
3	Housekeeping	176,351	37,505		213,856		213,856		213,856			3
4	Laundry	51,317	20,187		71,504		71,504		71,504			4
5	Heat and Other Utilities			201,186	201,186		201,186	(1,831)	199,355			5
6	Maintenance	50,175		105,260	155,435		155,435	(8,810)	146,625			6
7	Other (specify):*											7
8	**TOTAL General Services**	718,051	304,262	317,252	1,339,565	(26,061)	1,313,504	(10,753)	1,302,751			8
	B. Health Care and Programs											
9	Medical Director			45,000	45,000		45,000		45,000			9
10	Nursing and Medical Records	2,177,655	178,024	11,944	2,367,623		2,367,623		2,367,623			10
10a	Therapy	113,067		828	113,895		113,895		113,895			10a
11	Activities	50,851	14,078	4,680	69,609		69,609		69,609			11
12	Social Services	99,418			99,418		99,418		99,418			12
13	CNA Training											13
14	Program Transportation			2,177	2,177		2,177		2,177			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,440,991	192,102	64,629	2,697,722		2,697,722		2,697,722			16
	C. General Administration											
17	Administrative	237,344		350,967	588,311		588,311		588,311			17
18	Directors Fees											18
19	Professional Services			64,699	64,699	(4,919)	59,780	(4,128)	55,652			19
20	Dues, Fees, Subscriptions & Promotions			64,626	64,626		64,626	(49,377)	15,249			20
21	Clerical & General Office Expenses	112,596	54,859	148,946	316,401		316,401	(99,331)	217,071			21
22	Employee Benefits & Payroll Taxes			749,750	749,750	26,061	775,811		775,811			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,544	2,544		2,544	(250)	2,294			24
25	Other Admin. Staff Transportation			7,861	7,861		7,861	(1,943)	5,918			25
26	Insurance-Prop.Liab.Malpractice			185,692	185,692		185,692		185,692			26
27	Other (specify):*											27
28	**TOTAL General Administration**	349,940	54,859	1,575,085	1,979,884	21,142	2,001,026	(155,029)	1,845,997			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,508,982	551,223	1,956,966	6,017,171	(4,919)	6,012,252	(165,782)	5,846,470			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Ambassador Nursing Center #0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			44,103	44,103		44,103	87,016	131,119			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			137,436	137,436		137,436	123,516	260,952			32
33	Real Estate Taxes			222,500	222,500	4,919	227,419		227,419			33
34	Rent-Facility & Grounds			143,809	143,809		143,809	(143,809)				34
35	Rent-Equipment & Vehicles			27,746	27,746		27,746		27,746			35
36	Other (specify):*							2,338	2,338			36
37	**TOTAL Ownership**			575,594	575,594	4,919	580,513	69,061	649,574			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		389,469	324,369	713,838		713,838		713,838			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):*	34,065			34,065		34,065	(34,065)	0			43
44	**TOTAL Special Cost Centers**	34,065	389,469	428,394	851,928		851,928	(34,065)	817,863			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,543,047	940,692	2,960,954	7,444,693	(0)	7,444,693	(130,786)	7,313,907			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,831)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	29,868	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(112)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,467)	21		18
19	Entertainment	(1,692)	21		19
20	Contributions	(2,092)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(62,500)	21		24
25	Fund Raising, Advertising and Promotional	(23,100)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(711)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(13,412)	20		28
29	Other-Attach Schedule	(215,086)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (299,138)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	168,352		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 168,352		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (130,786)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Ambassador Nursing Center

ID# 0004077

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Salaries-Marketing	$ (34,065)	43	1
2	Bank Charges	(2,898)	21	2
3	Use Tax	(4,429)	21	3
4	Building Company - Loan Fees	(22,515)	21	4
5	Building Company - Bank Charges	(106)	21	5
6	Building Company - Managrment Fees	(55,000)	19	6
7	Non-Allowable Legal	(4,128)	19	7
8	Capitalized R&M	(8,810)	06	8
9	Non-Allowable Seminar	(258)	24	9
10	Non-Allowable Costs	(18,633)	21	10
11	PPA Dues and Fees	(10,773)	20	11
12	Building Company - Miscellaneous	(51,536)	21	12
13	Non Allowable Travel	(1,943)	25	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	**Total**	(215,086)		101

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Ambassador Nursing Center # 0004077 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(112)											(112)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,831)											(1,831)	5
6	Maintenance	(8,810)											(8,810)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(10,753)											(10,753)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(59,128)	55,000										(4,128)	19
20	Fees, Subscriptions & Promotions	(49,377)											(49,377)	20
21	Clerical & General Office Expenses	(173,488)	74,157										(99,331)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(250)											(250)	24
25	Other Admin. Staff Transportation	(1,943)											(1,943)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(284,186)	129,157										(155,029)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(294,939)	129,157										(165,782)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Ambassador Nursing Center** **#** **0004077** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	29,868	57,148										87,016	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2)	123,518										123,516	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(143,809)										(143,809)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*		2,338										2,338	36
37	TOTAL Ownership	29,866	39,195										69,061	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(34,065)											(34,065)	43
44	TOTAL Special Cost Centers	(34,065)											(34,065)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(299,138)	168,352										(130,786)	45

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Ambassador Building Partnership		Bldg Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 143,809	Ambassador Building Partnership	100.00%	$	$ (143,809)	1
2	V	32	Mortagage Interest		Ambassador Building Partnership		123,518	123,518	2
3	V	36	Amortization Expense		Ambassador Building Partnership		2,338	2,338	3
4	V	21	Loan Fees		Ambassador Building Partnership		22,515	22,515	4
5	V	30	Depreciation		Ambassador Building Partnership		57,148	57,148	5
6	V	21	Bank Charges		Ambassador Building Partnership		106	106	6
7	V	21	Miscellaneous		Ambassador Building Partnership		51,536	51,536	7
8	V	19	Management Fees		Ambassador Building Partnership		55,000	55,000	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 143,809			$ 312,161	$ * 168,352	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Meisels	Executive Admin.	Administrative	Relative	See Attached	7.39	18.00%	See Attached	$ 138,633	17-1,17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 138,633		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

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1						$	$		$	1
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23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

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1						$	$		$	1
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22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

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2										2
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6										6
7										7
8										8
9										9
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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

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22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

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22										22
23										23
24										24
25	TOTALS					$	$		$	25

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1						$	$		$	1
2										2
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5										5
6										6
7										7
8										8
9										9
10										10
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22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

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2										2
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5										5
6										6
7										7
8										8
9										9
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Continental Care	X		Mortgage			$	$ 483,868			$ 79,784	1
2	American Charter		X	Mortgage				259,973			21,554	2
3	Bank Financial		X	Mortgage				1,936,392			123,518	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank Financial		X	Line of Credit				1,481,983			36,102	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 4,162,216			$ 260,958	9
	B. Non-Facility Related*											
10	Interest Income		X								(2)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (2)	14
15	TOTALS (line 9+line14)						$	$ 4,162,216			$ 260,956	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Ambassador Nursing Center # 0004077 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 241,367	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 210,280	2
3. Under or (over) accrual (line 2 minus line 1).	$ (31,087)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 253,587	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$ 4,919	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 227,419	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	225,047	8
	2001	230,900	9
	2002	233,489	10
	2003	225,293	11
	2004	210,280	12

2005 RE Estate Tax Accrual - $237,600x1.17%=$276,101

Beginning accrual adjusted by $3,767

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ambassador Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0004077

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-418-021-0000	Long Term Care Property	$ 18,555.26	$ 18,555.26
2.	13-11-418-022-0000	Long Term Care Property	$ 68,197.41	$ 68,197.41
3.	13-11-418-026-0000	Long Term Care Property	$ 86,701.93	$ 86,701.93
4.	13-11-418-028-0000	Long Term Care Property	$ 33,491.62	$ 33,491.62
5.	13-11-418-033-0000	Long Term Care Property	$ 3,333.74	$ 3,333.74
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 210,279.96	$ 210,279.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ambassador Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0004077

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,497 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1977	$ 127,394	1
2					2
3	TOTALS			$ 127,394	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1983	820		20			820	9
10	Various			1984	11,000		20			11,000	10
11	Various			1986	44,252		20	1,880	1,880	44,136	11
12	Various			1987	5,800		20	290	290	5,365	12
13	Various			1988	1,825		20	58	58	1,005	13
14	Various			1990	48,352		20	1,708	1,708	26,074	14
15	Various			1991	1,571		20	79	79	1,124	15
16	Various			1992	8,653		20	432	432	5,797	16
17	Various			1993	55,217		20	2,531	2,531	40,786	17
18	Various			1994	8,007		20	401	401	4,332	18
19	Various			1995	35,063		20	1,753	1,753	18,138	19
20	Various			1996	120,434		20	6,022	6,022	57,682	20
21	Various			1997	37,040		20	1,853	1,853	15,580	21
22	Various			1998	127,674		20	6,195	6,195	45,127	22
23	Various			1999	139,435		20	6,972	6,972	44,077	23
24	Various			2000	85,574		20	2,962	2,962	16,580	24
25	Various			2001	90,840		20	2,535	2,535	11,763	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,714,426	57,148			(57,148)	1,628,710	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)								68
69	Financial Statement Depreciation			44,103			(44,103)		69
70	TOTAL (lines 4 thru 69)		$ 2,535,983	$ 101,251		$ 35,671	$ (65,580)	$ 1,978,096	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,535,983	$ 101,251		$ 35,671	$ (65,580)	$ 1,978,096	1
2	Install Faucets	2002	648		20	65	65	248	2
3	Install Faucets	2002	1,780		20	178	178	682	3
4	Install Smoke/Fire Damper	2002	1,170		20	117	117	439	4
5	Concrete Restoration	2002	4,575		20	458	458	1,678	5
6	Walk In Freezer	2002	2,420		20	242	242	867	6
7	Leasehold Improvements	2002			20				7
8	Post Terminal/Battery Cable Generator	2002	850		20	43	43	135	8
9	Water Pump - Generator	2002	1,216		20	61	61	187	9
10	Masonry Restoration	2002	2,750		20	275	275	963	10
11	Fire Alarm	2002	592		20	85	85	338	11
12	Tiles	2002	1,053		20	105	105	421	12
13	Cooling System	2002	4,287		20	429	429	1,608	13
14	Painting	2002	2,725		20			2,725	14
15	Call System	2002	516		20	34	34	112	15
16	Receptacles	2002	600		20	60	60	190	16
17	Window Shades Wound Care	2003	1,281		20	128	128	277	17
18	Wall Covering	2003	16,578		20	829	829	1,727	18
19	Jetvac Floor Drains	2003	2,451		20	245	245	633	19
20	Sump Pump	2003	1,761		20	176	176	426	20
21	10 Push Button Locks	2003	1,377		20	138	138	333	21
22	Mixing Value High Temp	2003	3,171		20	317	317	740	22
23	Wound Care Unit Decorat	2003	2,564		20	256	256	598	23
24	Damper Test List Zones	2003	1,800		20	46	46	112	24
25	Hot Water Pump Repair	2003	1,323		20	66	66	182	25
26	Fire Door	2003	710		20	36	36	86	26
27	Plumbing Supplies	2003	593		20	30	30	69	27
28	Hot Water - Plumbing	2003	548		20	27	27	64	28
29	Electrical Receptacles	2003	2,160		20	108	108	243	29
30	Boiler Repair	2003	5,395		20	270	270	562	30
31	Service On Paging System	2004	483		20	48	48	97	31
32	Voice Process For Rear And Front Door	2004	858		20	86	86	172	32
33	P.A. System And Outlet Work	2004	922		20	92	92	184	33
34	TOTAL (lines 1 thru 33)		$ 2,605,140	$ 101,251		$ 40,721	$ (60,530)	$ 1,995,194	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,605,140	$ 101,251		$ 40,721	$ (60,530)	$ 1,995,194	1
2	Install Monitoring System	2004	820		20	82	82	164	2
3	Digital Video Recorder	2004	1,363		20	136	136	273	3
4	Cctv System Kitchen Exit And Dining Room	2004	988		20	99	99	189	4
5	Cctv System At Front Entrance	2004	1,423		20	142	142	273	5
6	Cctv System Basement Corridor	2004	961		20	96	96	184	6
7	Fire Alarm System	2004	3,335		20	334	334	472	7
8	Downpayment For Remodeling	2004	25,000		20	2,500	2,500	3,125	8
9	1St Floor Resident Bathroom Flooring	2004	6,662		20	666	666	777	9
10	Replace/Remodel Various	2004	194,872		20	19,487	19,487	21,111	10
11	Fire Alarm System	2004	181,423		20	18,142	18,142	22,678	11
12	Closet Doors	2004	990		20	99	99	190	12
13	Kitchen Monitoring System	2004	1,958		20	196	196	359	13
14	Latching Alarm System	2004	2,207		20	221	221	423	14
15	Latching Alarm System	2004	1,859		20	186	186	356	15
16	Wiring	2004	883		20	88	88	140	16
17	Plumbing	2004	1,975		20	198	198	296	17
18	Plumbing	2004	2,758		20	276	276	414	18
19	Parking Lot Repair	2004	1,375		20	138	138	195	19
20	Fire Pump Repairs	2004	3,335		20	334	334	472	20
21	Paint	2004	509		20	51	51	64	21
22	Handrail	2004	1,922		20	192	192	384	22
23	Paint	2004	745		20	75	75	118	23
24	Paint	2004	698		20	70	70	99	24
25	Freight For Various Improvements	2005	9,238		20	366	366	366	25
26	Bumper Guards	2005	4,039		20	160	160	160	26
27	Hvac	2005	19,919		20	539	539	539	27
28	Hydraulic Pump	2005	4,100		20	94	94	94	28
29	Lucite Tops	2005	3,007		20	56	56	56	29
30	Elevator	2005	3,614		20	68	68	68	30
31	Elevator	2005	1,450		20	21	21	21	31
32	Elevator	2005	98,636		20	1,438	1,438	1,438	32
33	Elevator	2005	4,915		20	51	51	51	33
34	TOTAL (lines 1 thru 33)		$ 3,192,119	$ 101,251		$ 87,322	$ (13,929)	$ 2,050,743	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,192,119	$ 101,251		$ 87,322	$ (13,929)	$ 2,050,743	1
2	Elevator	2005	630		20	7	7	7	2
3	Elevator	2005	870		20	9	9	9	3
4	Elevator	2005	975		20	10	10	10	4
5	Elevator	2005	870		20	2	2	2	5
6	Elevator	2005	975		20	2	2	2	6
7	Smoke Detectors	2005	1,167		20	2	2	2	7
8	Sprinkler System	2005	585		20	1	1	1	8
9	Floor Covering	2005	7,593		20	174	174	174	9
10	Coil	2005	1,936		20	194	194		10
11	Motor	2005	3,449		20	345	345		11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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15									15
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,211,169	$ 101,251		$ 88,068	$ (13,184)	$ 2,050,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	190		1977	1977	$ 1,714,426	$ 57,148		$	$ (57,148)	$ 1,628,710	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,714,426	$ 57,148		$	$ (57,148)	$ 1,628,710	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 536,583	$	$ 42,709	$ 42,709	10	$ 410,723	71
72	Current Year Purchases	3,425		343	343	10		72
73	Fully Depreciated Assets	448,017				10	448,017	73
74								74
75	TOTALS	$ 988,025	$	$ 43,052	$ 43,052		$ 858,740	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,326,588	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 101,251	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 131,119	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,868	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,909,690	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 22,133 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Various		$ Various	$ 5,613	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,613	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 162,362	$		$ 162,362	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			10,544			10,544	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			151,463			151,463	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				237,931		237,931	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						151,538		151,538	13
14	TOTAL			$		$ 324,369	$ 389,469		$ 713,838	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center **#** 0004077 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,130	$ 4,246	1
2	Cash-Patient Deposits	63,260	63,260	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,338,232	2,493,682	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,539	92,539	6
7	Other Prepaid Expenses	90,252	90,252	7
8	Accounts Receivable (owners or related parties)	1,701,022	1,184,873	8
9	Other(specify): See Attached Schedule	114,058	219,198	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,401,493	$ 4,148,050	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		127,394	13
14	Buildings, at Historical Cost		1,714,426	14
15	Leasehold Improvements, at Historical Cost	1,281,454	1,292,547	15
16	Equipment, at Historical Cost	827,842	1,055,424	16
17	Accumulated Depreciation (book methods)	(1,005,839)	(2,873,152)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		47,621	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,626)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,103,457	$ 1,357,634	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,504,950	$ 5,505,684	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,792,276	$ 1,792,277	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	63,260	63,260	28
29	Short-Term Notes Payable	743,841	743,841	29
30	Accrued Salaries Payable	141,928	141,928	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	253,587	253,587	32
33	Accrued Interest Payable	5,764	13,898	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	726,611	726,611	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,727,267	$ 3,735,402	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,481,983	1,481,983	39
40	Mortgage Payable		1,936,392	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,481,983	$ 3,418,375	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,209,250	$ 7,153,777	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 295,700	$ (1,648,093)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,504,950	$ 5,505,684	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 172,474	1	
2	Restatements (describe):		2	
3	**Detail Will Be Sent Under Separate Cover**	58,856	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 231,330	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	64,370	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 64,370	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 295,700	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,583,487	1
2	Discounts and Allowances for all Levels	(1,233,818)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,349,669	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	896,900	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 896,900	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	192,941	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,756	19
20	Radiology and X-Ray	9,710	20
21	Other Medical Services	47,085	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 262,492	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,509,063	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,339,565	31
32	Health Care	2,697,722	32
33	General Administration	1,979,884	33
	B. Capital Expense		
34	Ownership	575,594	34
	C. Ancillary Expense		
35	Special Cost Centers	747,903	35
36	Provider Participation Fee	104,025	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,444,693	40
41	**Income before Income Taxes (line 30 minus line 40)****	64,370	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 64,370	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,264	1,366	$ 47,265	$ 34.60	1
2	Assistant Director of Nursing	2,032	2,184	65,701	30.08	2
3	Registered Nurses	19,671	20,516	510,693	24.89	3
4	Licensed Practical Nurses	34,688	35,064	719,957	20.53	4
5	CNAs & Orderlies	77,642	83,513	803,531	9.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,509	6,121	113,067	18.47	8
9	Activity Director					9
10	Activity Assistants	5,748	6,065	50,851	8.38	10
11	Social Service Workers	5,616	5,863	99,418	16.96	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,160	41,276	19.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,330	42,396	398,932	9.41	15
16	Dishwashers					16
17	Maintenance Workers	2,763	2,955	50,175	16.98	17
18	Housekeepers	21,062	22,111	176,351	7.98	18
19	Laundry	5,992	6,444	51,317	7.96	19
20	Administrator	2,104	2,363	93,924	39.75	20
21	Assistant Administrator	1,912	2,080	46,154	22.19	21
22	Other Administrative	2,032	2,080	97,266	46.76	22
23	Office Manager					23
24	Clerical	7,389	8,186	112,596	13.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,190	2,582	30,508	11.82	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	952	1,201	34,065	28.36	33
34	TOTAL (lines 1 - 33)	238,800	255,250	$ 3,543,047 *	$ 13.88	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	205	$ 10,806	01-03	35
36	Medical Director	Monthly	45,000	09-03	36
37	Medical Records Consultant	60	3,590	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	18	828	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	94	4,680	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	377	$ 64,904		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 8,354	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 8,354		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William McNiff	Administrator	0	$ 16,542
Mary VonGoeben	Administrator	0	77,382
Patrica Correa	Asst Administrator	0	46,154
David Meisels	Executive Admin	Relative	97,266
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 237,344

B. Administrative - Other

Description	Amount
Olympia Group, LLC (Owners of Olympia Group are not related to the Owner of the Facility)	$ 309,600
David Meisels	41,367
TOTAL (agree to Schedule V, line 17, col. 3)	$ 350,967
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 20,089
Personnel Planners, Inc.	Unemployment Consulting	2,220
See Attached Schedule	Legal	16,172
HDSI	Computer Services	8,340
AccuMed Service	Computer Services	3,060
KIPP Computer	Computer Services	4,800
Liquid Print	Computer Services	689
Oak Computer	Computer Services	1,006
Emedon Business Services	Computer Services	315
RSM McGladrey	Accounting Fees	223
HPSI	Purchasing Consultant	175
SMS	Medicare Consulting	7,611
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 64,699

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,433
Unemployment Compensation Insurance	98,141
FICA Taxes	267,889
Employee Health Insurance	223,893
Employee Meals	26,061
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	8,609
Chicago Head Tax	1,608
401K Expense	1,181
Disability Insurance	5,292
Union Pension	24,933
Other Employee Benefits	40,772
TOTAL (agree to Schedule V, line 22, col.8)	$ 775,811

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,369
Health Care Worker Background Check	
(Indicate # of checks performed 21)	520
Dues & Subscriptions	5,440
Licenses & Fees	2,920
Advertising & Promotion	23,100
Yellow Page Advertising	13,412
Less: Public Relations Expense	( )
Non-allowable advertising	(23,100)
Yellow page advertising	(13,412)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,249

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,294
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,294

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Ambassador Nursing Center # 0004077 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Center # 0004077 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,509** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **104,025**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **26,061** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.